

Exhibit F

Davis Hospital and Medical Center

Patient Information

Patient Name: ABREU, ANGEL
Home Address:

Sex: Male
DOB: 02/21/96
Age: 25 Years
Religion:
SSN:
Race:

Home Phone: Cell Phone:
Employer Name:
Employer Phone:

Guarantor Information

Guarantor Name:
Patient's Reltn:
Billing Address:

Sex:
DOB:
Age:
Religion:
SSN:
Marital Status:

Billing Phone:
Employer Name:
Employer Phone:

Contact InformationEmergency Contact

Contact Name:
Patient's Reltn:
Sex:
Home Phone:

Next of Kin

Contact Name:
Patient's Reltn:
Sex:
Home Phone:

Primary Insurance

Subscriber Name:
Patient's Reltn:
Sex:
DOB:
Age:
Employer Name:
Employer Phone:
Financial Class:
Group Name:

Insurance Name:
Claim Address:

Insurance Phone:
Policy Number:
Group Number:
Authorization Number:
Authorization Phone:
Authorization Contact:

Secondary Insurance

Subscriber Name:
Patient's Reltn:
Sex:
DOB:
Age:
Employer Name:
Employer Phone:
Financial Class:
Group Name:

Insurance Name:
Claim Address:

Insurance Phone:
Policy Number:
Group Number:
Authorization Number:
Authorization Phone:
Authorization Contact:

Encounter Information

Reg Dt/Tm: 09/26/2020 20:50
Est Dt of Arrival:
Inpt Adm Dt/Tm:
Disch Dt/Tm: 09/26/20 21:20 MDT
Observation Dt/Tm: 09/26/2020 20:51
VIP Indicator:
Admit Reason: Trauma one

Patient Type: Emergency
Medical Service: Emergency Services
Location: DHM ED
Room/Bed: ED21 / A
Isolation:
Disease Alert:

Admit Type:
Admit Source:
Advance Directive:
Reg Clerk: Farnworth, ED Tech, Mariah
Admit Physician:
Attend Physician:
PCP:

ABREU, ANGEL
MRN: 1202347827

Male / 25 Years
FIN: DHM-18000351106



Davis Hospital and Medical Center

1600 West Antelope Drive

Layton, UT 84041-1142

Patient Name: **ABREU, ANGEL**MRN: **1202347827**Encounter: **DHM-18000351106**Age: **25 years**Gender: **Male**DOB: **2/21/1996**Admit Date: **9/26/2020**Discharge Date: **9/26/2020**

Attending MD:

Consultation Notes

Document Type:

Service Date/Time:

Result Status:

Document Subject:

Sign Information:

Surgery Consultation

9/26/2020 20:51 MDT

Auth (Verified)

Consult Note

Baker,MD,Scott L (9/26/2020 20:54 MDT)

Chief Complaint

Found in jail with stabwound to left abdomen. In police custody. Police at bedside. Pt remains in handcuffs.

Referring Physician

Level 1 trauma

Reason for Consultation

Abdominal stab wound

History of Present Illness

Male was found in his jail cell. He barricaded himself in. He is allergic to drugs in his jail cell. Did some self-inflicted stab wound to his abdomen. He was then brought to the emergency room. Did have a decreased level of consciousness. Seen initially in the trauma bay. Airway was intact breath sounds were equal bilaterally. Blood pressure and heart rate were stable. Did have evidence of stab wound in the left lower abdomen. Did not appear to penetrate the abdominal wall.

Review of Systems

Constitutional: No fevers, chills, sweats, weight loss

Eye: No visual problems

HENT: No ear pain, nasal congestion, sore throat

Respiratory: No shortness of breath, cough

Cardiovascular: No Chest pain or palpitations

Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea

Genitourinary: No hematuria, no dysuria

Hema/Lymph: Negative for bruising tendency, swollen lymph glands

Endocrine: Negative for excessive thirst, no heat or cold intolerance

Musculoskeletal: No back pain, joint pain, muscle pain

Integumentary: No rash, pruritus, abrasions, no skin ulcers

Neurologic: No focal weakness, no seizures or tremors

Psychiatric: Normal memory, normal mood

Physical Exam**Vitals & Measurements**

WT: 98.7 kg (Measured) WT: 98.70 kg (Dosing)

General: Well nourished, no acute distress

Eye: PERRL, normal conjunctiva, sclerae non-icteric

HENT: Normocephalic, normal hearing, moist oral mucosa, no sinus tenderness

Neck: Supple, non-tender, no lymphadenopathy

Allergies

No Known Allergies

Medication List**Inpatient**

No active inpatient medications

Home

No active home medications

Immunizations

tetanus/diphth/pertuss (Tdap) adult/adol: 0.5 mL

Problem List/Past Medical History

No chronic problems

Historical

No historical problems

Family History

After complete review of the patient's family history, there are no relevant diseases or illnesses.

Social History**Tobacco**

Never smoker

Diagnostics

XR Chest 1 View Frontal

09/26/20 19:55:51

IMPRESSION:

No radiographic evidence for acute thoracic disease.

Signed By: Walker, DO, Kyle R

CT Abdomen and Pelvis w/ Contrast

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Consultation Notes

Lungs: Clear to auscultation, no respiratory distress, no wheeze, rales, or rhonchi
 CV: Normal rate, regular rhythm
 Abdomen: Soft, nontender stab wound to the left lower abdomen. Appears to be approximately 3 cm in length. Subcutaneous nature does not appear to penetrate through the anterior rectus fascia, non-distended, normal bowel sounds,
 Musculoskeletal: No muscular tenderness, no joint pain
 Skin: Warm, dry, normal turgor
 Lymphatic No cervical or inguinal adenopathy
 Neurologic: Alert and oriented X3, no motor deficit
 Psychiatric: Cooperative, appropriate mood and affect

Assessment/Plan

1. Laceration of abdominal wall
 Laceration to the anterior abdominal wall. This is then closed loosely with staples. Does not appear to be contaminated.
2. Rectal foreign body
 Evidence of rectal foreign body appears to be a ring this was confirmed by the patient as well as some string of rubber tubing attached. He felt that this was his phone numbers wrapped in Saran wrap that he put in his rectum as well. Recommend passing on its own.
3. Substance abuse

Diagnosis Coding Information

S31.119A Laceration without foreign body of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter
T18.5XXA Foreign body in anus and rectum, initial encounter
F19.10 Other psychoactive substance abuse, uncomplicated

09/26/20 20:00:00

IMPRESSION:

1. Skin and subcutaneous laceration in the left lower in the supraumbilical fat of the left abdominal quadrant. No evidence for extension into the peritoneal cavity.
2. No evidence for an acute abdominal or pelvic organ injury.
3. Ring shaped metallic foreign body in the rectum with additional radiopaque tubing extending proximally towards the anus consistent with a retained rectal foreign body.

Findings discussed by telephone with Dr. Baker at 2036 hours on 9/26/2020.

Signed By: Walker, DO, Kyle R

Electronically Signed on 09/26/20 08:54 PM

Baker, MD, Scott L

Emergency Documentation

Document Type:	ED Note Physician
Service Date/Time:	9/26/2020 21:40 MDT
Result Status:	Auth (Verified)
Document Subject:	ED Note
Sign Information:	Grow,MD,Robert W (9/26/2020 21:40 MDT)

Basic Information

Chief Complaint

Found in jail with stabwound to left abdomen. In police custody. Police at bedside. Pt remains in handcuffs.

ED Assigned Provider/Time

Time Seen:
 Grow, MD, Robert W / 09/26/2020 19:54

Problem List/Past Medical History

No chronic problems

Historical

No historical problems

Medications

Inpatient

No active inpatient medications

Home

No active home medications

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Emergency Documentation

History of Present Illness

Patient is a long-term resident at the local jail. Apparently today he barricaded himself in his room. Once officers gained access he was found to be less responsive with potentially a piece of candy stuck in his throat. He had lacerated his abdomen. He had been found earlier today to be in possession of both Suboxone and methamphetamines. No other injuries were identified. The patient has been hemodynamically stable.

Review of Systems

Constitutional: [No fevers, chills, sweats, weight loss]
 Eye: [No visual problems]
 ENMT: [No ear pain, nasal congestion, sore throat]
 Respiratory: [No shortness of breath, cough]
 Cardiovascular: [No Chest pain, palpitations, syncope, swelling in legs, dyspnea on exertion]
 Gastrointestinal: [Has abdominal pain, no nausea, no vomiting, no diarrhea, no difficulty swallowing]
 Genitourinary: [No hematuria, no dysuria, no hesitancy, no frequency, no incontinence]
 Hema/Lymph: [Negative for bruising tendency, swollen lymph glands]
 Endocrine: [Negative for excessive thirst, glucose normal, no heat or cold intolerance]
 Musculoskeletal: [No back pain, neck pain, joint pain, muscle pain, decreased range of motion]
 Integumentary: [No rash, pruritus, abrasions, no skin ulcers]
 Neurologic: [No focal weakness, no paresthesia, no headaches, numbness or tingling, no seizures or tremors]
 Psychiatric: [Normal memory, normal mood]
 Skin: No rashes, sores, or lesions

All other systems reviewed are negative or normal.

Physical Exam

Vitals & Measurements

T: 36.8 °C BP: 115/74 SpO2: 97%
 WT: 98.7 kg (Measured) WT: 98.70 kg (Dosing)
 CONSTITUTIONAL: _Patient appears somewhat sleepy but he does open his eyes and answers questions appropriately
 SKIN: _warm, dry, no jaundice, hives or petechiae
 EYES: _pupils are equally round, extraocular movements intact without nystagmus, clear conjunctiva, non-icteric sclera
 HENT: _normocephalic, atraumatic, moist mucus membranes, oropharynx clear without exudates, TMs and mastoids normal
 NECK: _Nontender and supple with no nuchal rigidity, no lymphadenopathy, full range of motion
 PULMONARY: _clear to auscultation without wheezes, rhonchi, or rales, normal excursion, no accessory muscle use and no stridor
 CARDIOVASCULAR: _Mild tachycardia, regular rhythm. No appreciated murmurs. Strong radial pulses with intact distal perfusion
 GASTROINTESTINAL: _There is a 3 cm linear laceration that somewhat gaping with exposure of underlying fat in the mid left abdomen. No other penetrating wounds are identified. Palpation of the wound feels deep to the peritoneum but not through the peritoneal fascia. Abdomen is soft, non-distended, no palpable masses, no rebound or guarding, bowel sounds normal
 GENITOURINARY: _No costovertebral angle tenderness
 LYMPHATICS: _no edema in lower extremities, no lymphadenopathy
 MUSCULOSKELETAL: _Extremities are nontender to palpation and have no gross deformity, no edema, redness, or swelling

Allergies

No Known Allergies

Social History

Tobacco

Never smoker

Lab Results

CBC and Differential	LATEST RESULTS
WBC	09/26/20 10.7 High 20:00
RBC	09/26/20 4.38 Low 20:00
Hgb	09/26/20 13.9 Low 20:00
Hct	09/26/20 40.1 20:00
MCH	09/26/20 31.6 20:00
MCHC	09/26/20 34.6 20:00
RDW	09/26/20 13.0 20:00
MCV	09/26/20 91.5 20:00
Platelets	09/26/20 288 20:00
MPV	09/26/20 6.7 Low 20:00
Neutro Auto	09/26/20 56.5 20:00
Lymph Auto	09/26/20 30.7 20:00
Mono Auto	09/26/20 12.3 High 20:00
Eos, Auto	09/26/20 0.2 20:00
Basophil Auto	09/26/20 0.3 20:00
Neutro Absolute	09/26/20 6.0 20:00
Lymph Absolute	09/26/20 3.3 20:00
Mono Absolute	09/26/20 1.3 High 20:00
Slide Review	09/26/20 Auto 20:00

Coagulation LATEST RESULTS

Prothrombin Time	09/26/20 13.8 20:00
INR	09/26/20 1.2 High 20:00

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Emergency Documentation

NEUROLOGIC: The patient is alert and oriented to person, place, and time with normal speech. No motor deficits are noted, with muscle strength 5/5 bilaterally. Sensation is intact bilaterally. Reflexes are 2+ bilaterally. Cranial nerves are intact. Cerebellar function is intact. Memory is normal and thought process is intact. No gait abnormalities are appreciated.

PSYCHIATRIC: _Challenging to assess but seems at baseline

Procedure

No qualifying data available.

Medical Decision Making

In more discussion with the officers, they tell me that they did find some substances in male that he had received although he did not have access to that they feel that it is likely that he already had some in his cell. However the patient even after very short timeframe of being here he seemed completely awake and appropriate, no change in mental status, nothing to suggest ongoing ingestion or intoxication. CT scan of the abdomen demonstrates that the laceration does not penetrate the peritoneal cavity which is consistent with our exam. He is found to have a foreign body in his rectum felt to be a reading. The officers are aware of this and will monitor the patient's stool. I do not think there is need to try and extricate this at this point. Dr. Baker has evaluated the patient here in the emergency department as he did respond to the trauma 1 activation. He has cleansed and closed the laceration in the abdominal wall. Continued wound management has been discussed. The patient will be discharged back to the jail infirmary for further management and monitoring. He has been hemodynamically stable here. There are no other identifiable injuries at this point.

Diagnosis/Assessment/Plan

1. Laceration of abdominal wall
2. Rectal foreign body
3. Substance abuse

Orders:

Discharge Patient
 Insert Peripheral IV with Saline lock
 Lactic Acid, Plasma (Venous)
 Urine DOA

Diagnosis Coding Information

S31.119A Laceration without foreign body of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter
T18.5XXA Foreign body in anus and rectum, initial encounter
F19.10 Other psychoactive substance abuse, uncomplicated

Partial 09/26/20 31.7
 Thromboplastin 20:00
 Time

Routine Chemistry	LATEST RESULTS
Sodium Level	09/26/20 141 20:00
Potassium Level	09/26/20 3.9 20:00
Chloride Level	09/26/20 107 20:00
CO2	09/26/20 26 20:00
BUN	09/26/20 11 20:00
Creatinine Level	09/26/20 1.0 20:00
BUN/Creat Ratio	09/26/20 11.0 20:00
eGFR AA	09/26/20 109 20:00
eGFR Non-AA	09/26/20 90 20:00
Glucose Level	09/26/20 73 20:00
Calcium Level	09/26/20 9.9 20:00
Anion Gap	09/26/20 8 20:00
Alk Phos	09/26/20 47 20:00
Bilirubin Total	09/26/20 0.6 20:00
AST	09/26/20 35 20:00
ALT	09/26/20 29 20:00
Protein Total	09/26/20 7.4 20:00
Albumin Level	09/26/20 4.90 High 20:00
Globulin	09/26/20 2.5 20:00
A/G Ratio	09/26/20 2.0 20:00
Lactic Acid, Plasma (Venous)	09/26/20 2.2 High 20:00

Transfusion Medicine Testing **LATEST RESULTS**

Patient Name: **ABREU, ANGEL**
MRN: **1202347827**
Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
Discharge Date: **9/26/2020**

Emergency Documentation

Pulse,bpm 09/26/20 94 bpm
21:19

Diagnostic Results

XR Chest 1 View Frontal

09/26/20 19:55:51

IMPRESSION:

No radiographic evidence for acute thoracic disease.

Signed By: Walker, DO, Kyle R

CT Abdomen and Pelvis w/ Contrast

09/26/20 20:00:00

IMPRESSION:

1. Skin and subcutaneous laceration in the left lower in the supraumbilical fat of the left abdominal quadrant. No evidence for extension into the peritoneal cavity.
2. No evidence for an acute abdominal or pelvic organ injury.
3. Ring shaped metallic foreign body in the rectum with additional radiopaque tubing extending proximally towards the anus consistent with a retained rectal foreign body.

Findings discussed by telephone with Dr. Baker at 2036 hours on 9/26/2020.

Signed By: Walker, DO, Kyle R

Patient Education and Follow Up

Documented Patient Education

LACERATION, Trunk - 09/26 20:38

Follow Up Appointments

Staple removal in 10 days. within 1 to 2 days

Electronically Signed on 09/26/20 09:40 PM

Grow, MD, Robert W

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Emergency Documentation

Document Type:	ED Notes
Service Date/Time:	9/26/2020 21:19 MDT
Result Status:	Auth (Verified)
Document Subject:	Disposition Documentation
Sign Information:	Dickerson, RN ICU Float, Melissa (9/26/2020 21:19 MDT)

Disposition Documentation Entered On: 9/26/2020 21:20 MDT
Performed On: 9/26/2020 21:19 MDT by Dickerson, RN ICU Float, Melissa

Disposition Documentation

Patient Condition-Disposition : Satisfactory
ED Procedural Sedation : No
ED Restraint/Seclusion : No
ED Vital Sign documentation : Open vital signs documentation
ED Assistance Summary Documentation : Open assistance summary documentation
ED Discharged to : Law enforcement detention
ED IV Supply Capture : Document
ED Discharge Documentation : Open Discharge Documentation

Dickerson, RN ICU Float, Melissa - 9/26/2020 21:19 MDT

Assistance Summary

ED Assistance Summary Not Applicable : N/A

Dickerson, RN ICU Float, Melissa - 9/26/2020 21:19 MDT

Vitals/Ht/Wt

Numeric Pain Scale : 0 = No pain
ED Traumatic Injury : Yes
Systolic/Diastolic BP : 74 mmHg
Systolic/Diastolic BP : 115 mmHg
Temperature (Route Not Specified) : 36.8 Deg C
Pulse : 94 bpm
Respiration Rate : 15
O2 Sat : 97 %

Dickerson, RN ICU Float, Melissa - 9/26/2020 21:19 MDT

Discharge

Discharged to care of : Correctional officer
Mode of Discharge : Wheelchair
Discharge Transportation : Other: police vehicle
ED Rx to Patient : No
Individuals Taught : Patient
Home Caregiver Present for Session : N/A
Teaching Method - ED : Written/printout, Explanation
Barriers to Learning : None evident
Discharge comments ED : instructions given to correctional officers and patient.

Dickerson, RN ICU Float, Melissa - 9/26/2020 21:19 MDT

ED IV Supply Capture

ED NS 0.9% 1000ML : 1
ED Discharge Documentation : Open Discharge Documentation

Dickerson, RN ICU Float, Melissa - 9/26/2020 21:19 MDT

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Transfusion Medicine

Transfusion Medicine Testing

Collected Date 9/26/2020
 Collected Time 21:19 MDT
 Procedure
 Pulse,bpm 94

Chemistry

Procedure		Units	Reference Range
Sodium Level	141 ^{*1}	mmol/L	[132-146]
Potassium Level	3.9 ^{*1}	mmol/L	[3.5-5.5]
Chloride Level	107 ^{*1}	mmol/L	[99-109]
CO2	26 ^{*1}	mmol/L	[22-31]
BUN	11 ^{*1}	mg/dL	[9-23]
Creatinine Level	1.0 ^{*1}	mg/dL	[0.5-1.1]
BUN/Creat Ratio	11.0 ^{*1}		
eGFR AA	109 ^{i1 *1}	mL/min/1.73m2	[90-120]
eGFR Non-AA	90 ^{*1}	mL/min/1.73m2	[90-120]
Glucose Level	73 ^{*1}	mg/dL	[60-110]
Calcium Level	9.9 ^{*1}	mg/dL	[8.7-10.4]
Anion Gap	8 ^{*1}	mmol/L	[2-16]
Alk Phos	47 ^{*1}	U/L	[30-224]
Bilirubin Total	0.6 ^{*1}	mg/dL	[0.3-1.5]
AST	35 ^{*1}	U/L	[10-42]
ALT	29 ^{*1}	U/L	[10-49]
Protein Total	7.4 ^{*1}	g/dL	[5.7-8.2]
Albumin Level	4.90 ^{H*1}	g/dL	[3.20-4.80]
Globulin	2.5 ^{*1}	g/dL	[1.0-4.5]
A/G Ratio	2.0 ^{*1}		[1.0-999.0]
Lactic Acid,Plasma (Venous)	2.2 ^{H*1}	mmol/L	[0.5-2.0]

Interpretive Data

i1: eGFR AA

- A. A GFR greater than 90 ml/min is considered normal, but patients with proteinuria may have kidney damage with a normal GFR. Please refer to the following website for staging of kidney disease: <http://utahkidney.com/EducationResources/ChronicKidneyDisease>
- B. This GFR has been calculated assuming the patient is not African American; however, if the patient is African American, please multiply this result by 1.21.
- C. The GFR may not be accurate for pregnant women or for patients with rapidly changing creatinines or on dialysis. Caution should be used in applying this GFR to patients with malnutrition and on certain medications.

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Chemistry

Performing Locations

*1: This test was performed at:
 DHM Laboratory, 1600 West Antelope Drive, Layton, UT, 84041- , US

CMP

Collected Date 9/26/2020 9/26/2020
 Collected Time 20:33 MDT 20:00 MDT

Procedure		Units	Reference Range
BUN/Creat Ratio	-	11.0 ^{*1}	
eGFR AA	-	109 ^{i1 *1} mL/min/1.73m2	[90-120]
eGFR Non-AA	-	90 ^{*1} mL/min/1.73m2	[90-120]
Anion Gap	-	8 ^{*1} mmol/L	[2-16]
Alk Phos	-	47 ^{*1} U/L	[30-224]
Bilirubin Total	-	0.6 ^{*1} mg/dL	[0.3-1.5]
Protein Total	-	7.4 ^{*1} g/dL	[5.7-8.2]
Albumin Level	-	4.90 ^{H*1} g/dL	[3.20-4.80]
Globulin	-	2.5 ^{*1} g/dL	[1.0-4.5]
A/G Ratio	-	2.0 ^{*1}	[1.0-999.0]
Lactic Acid, Plasma (Venous)	-	2.2 ^{H*1} mmol/L	[0.5-2.0]
Weight Measured	98.7	- kg	[50-110]
Sodium Level	-	141 ^{*1} mmol/L	[132-146]
Chloride Level	-	107 ^{*1} mmol/L	[99-109]
CO2	-	26 ^{*1} mmol/L	[22-31]
BUN	-	11 ^{*1} mg/dL	[9-23]
Creatinine Level	-	1.0 ^{*1} mg/dL	[0.5-1.1]
Glucose Level	-	73 ^{*1} mg/dL	[60-110]
Calcium Level	-	9.9 ^{*1} mg/dL	[8.7-10.4]
Potassium Level	-	3.9 ^{*1} mmol/L	[3.5-5.5]
AST	-	35 ^{*1} U/L	[10-42]
ALT	-	29 ^{*1} U/L	[10-49]

Interpretive Data

i1: eGFR AA

- A. A GFR greater than 90 ml/min is considered normal, but patients with proteinuria may have kidney damage with a normal GFR. Please refer to the following website for staging of kidney disease: <http://utahkidney.com/EducationResources/ChronicKidneyDisease>
- B. This GFR has been calculated assuming the patient is not African American; however, if the patient is African American, please multiply this result by 1.21.
- C. The GFR may not be accurate for pregnant women or for patients with rapidly changing creatinines or on dialysis. Caution should be used in applying this GFR to patients with malnutrition and on certain medications.

Performing Locations

*1: This test was performed at:
 DHM Laboratory, 1600 West Antelope Drive, Layton, UT, 84041- , US

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Coagulation-Thrombosis

Collected Date 9/26/2020

Collected Time 20:00 MDT

Procedure	Units	Reference Range
Prothrombin Time	seconds	[9.6-14.7]
INR		[0.9-1.1]
Partial Thromboplastin Time	seconds	[23.1-38.3]

Interpretive Data

i2: INR

Therapeutic Range for Low Dose is 2.0-3.0 INR

Therapeutic Range for Moderate Dose is 2.5-3.5 INR

i3: Partial Thromboplastin Time

Therapeutic range for individuals on anticoagulant therapy is 61 - 90 seconds.

Performing Locations

*1: This test was performed at:
 DHM Laboratory, 1600 West Antelope Drive, Layton, UT, 84041- , US

Hematology

CBC and Differential

Collected Date 9/26/2020

Collected Time 20:00 MDT

Procedure	Units	Reference Range
WBC	x10 ³ /mcL	[3.6-10.6]
RBC	x10 ⁶ /mcL	[4.40-5.80]
Hgb	g/dL	[14.0-18.0]
Hct	%	[38.0-52.0]
MCH	pg	[26.0-33.0]
MCHC	g/dL	[32.0-36.0]
RDW	%	[12.0-16.0]
MCV	fL	[80.0-97.0]
Platelets	x10 ³ /mcL	[140-440]
MPV	fL	[7.4-10.5]
Neutro Auto	%	[45.0-75.0]
Lymph Auto	%	[15.0-45.0]
Mono Auto	%	[2.0-10.0]
Eos,Auto	%	[0.0-5.0]
Basophil Auto	%	[0.0-3.0]
Neutro Absolute	x10 ³ /mcL	[1.5-7.5]
Lymph Absolute	x10 ³ /mcL	[0.4-3.3]
Mono Absolute	x10 ³ /mcL	[0.1-1.1]
Slide Review	Auto	

Performing Locations

*1: This test was performed at:
 DHM Laboratory, 1600 West Antelope Drive, Layton, UT, 84041- , US

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
 Discharge Date: **9/26/2020**

Chest X-Ray

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
12-XR-20-0016522	9/26/2020 20:07 MDT	XR Chest 1 View Frontal	Grow,MD,Robert W	Auth (Verified)

Reason For Exam

(XR Chest 1 View Frontal) Chest trauma

Report

INDICATION: Chest trauma.

EXAMINATION: Chest radiograph, portable frontal view.

COMPARISON: No relevant comparison.

VIEWS: Single frontal view of the chest.

FINDINGS:

Devices: None

Cardiomediastinal silhouette: Unremarkable.

Lungs: Unremarkable.

Pleural space: Unremarkable.

Bones and soft tissues: Normal for age.

Additional findings: None.

IMPRESSION:

No radiographic evidence for acute thoracic disease.

***** Final *****

Dictated by: Walker, DO, Kyle R

Dictated DT/TM: 09/26/2020 8:11 pm

Signed by: Walker, DO, Kyle R

Signed (Electronic Signature): 09/26/2020 8:11 pm

Computed Tomography

Accession	Exam Date/Time	Exam	Ordering Physician	Patient Age at Exam
12-CT-20-0011191	9/26/2020 20:13 MDT	CT Abdomen and Pelvis w/ Contrast	Grow,MD,Robert W	24 years

Reason for Exam

(CT Abdomen and Pelvis w/ Contrast) Abdominal pain

Patient Name: **ABREU, ANGEL**
MRN: **1202347827**
Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
Discharge Date: **9/26/2020**

Computed Tomography

Accession	Exam Date/Time	Exam	Ordering Physician	Patient Age at Exam
12-CT-20-0011191	9/26/2020 20:13 MDT	CT Abdomen and Pelvis w/ Contrast	Grow,MD,Robert W	24 years

Report

INDICATION: Self-inflicted abdominal wound.

EXAMINATION: CT Abdomen and Pelvis with Contrast

COMPARISON: Chest radiograph, 9/26/2020.

CONTRAST/MEDICATIONS:

IV: 100 ml of Omnipaque 350

Oral: None

(Contrast/medications administered according to protocol are authenticated)

TECHNIQUE: CT through the abdomen and pelvis was performed with contrast. Axial, coronal, and sagittal reconstructions performed.

Dose lowering technique(s) such as automated exposure control, iterative reconstruction, and mA and/or KV adjustment for patient's size was utilized for this exam.

FINDINGS:

Lower chest: Unremarkable.

Liver, biliary system, and pancreas: No focal liver lesion. Gallbladder and pancreas unremarkable.

Spleen: Normal.

Adrenal glands: Normal.

Kidneys, ureters, and urinary bladder: Normal kidneys, ureters, and bladder.

Lymph nodes: No lymphadenopathy.

Bowel and appendix: Stomach is nondistended. Duodenum and small bowel are nondilated. Terminal ileum appears normal. Normal appendix. No focal bowel wall thickening. Ring-shaped metallic density within the lumen of the sigmoid colon in addition to radiopaque tubing extending down towards the anus.

Reproductive organs: Normal appearance of the prostate gland.

Free fluid: No free intraperitoneal fluid.

Vasculature: Abdominal and pelvic vascular structures are unremarkable.

Osseous structures: No acute osseous abnormality.

Patient Name: **ABREU, ANGEL**
 MRN: **1202347827**
 Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
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Computed Tomography

Accession	Exam Date/Time	Exam	Ordering Physician	Patient Age at Exam
12-CT-20-0011191	9/26/2020 20:13 MDT	CT Abdomen and Pelvis w/ Contrast	Grow,MD,Robert W	24 years

Report

Additional findings: Skin staples in the long left ventral abdominal wall likely for closure of a laceration. No evidence for extension into the peritoneal cavity.

IMPRESSION:

1. Skin and subcutaneous laceration in the left lower in the supraumbilical fat of the left abdominal quadrant. No evidence for extension into the peritoneal cavity.
2. No evidence for an acute abdominal or pelvic organ injury.
3. Ring shaped metallic foreign body in the rectum with additional radiopaque tubing extending proximally towards the anus consistent with a retained rectal foreign body.

Findings discussed by telephone with Dr. Baker at 2036 hours on 9/26/2020.

***** Final *****

Dictated by: Walker, DO, Kyle R
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Diagnostic Radiology

Accession	Exam Date/Time	Exam	Ordering Physician	Patient Age at Exam
12-XR-20-0016522	9/26/2020 20:07 MDT	XR Chest 1 View Frontal	Grow,MD,Robert W	24 years

Reason for Exam

(XR Chest 1 View Frontal) Chest trauma

Report

INDICATION: Chest trauma.

EXAMINATION: Chest radiograph, portable frontal view.

COMPARISON: No relevant comparison.

VIEWS: Single frontal view of the chest.

FINDINGS:

Devices: None

Cardiomediastinal silhouette: Unremarkable.

Lungs: Unremarkable.

Patient Name: **ABREU, ANGEL**
MRN: **1202347827**
Encounter: **DHM-18000351106**

Admit Date: **9/26/2020**
Discharge Date: **9/26/2020**

Diagnostic Radiology

Accession	Exam Date/Time	Exam	Ordering Physician	Patient Age at Exam
12-XR-20-0016522	9/26/2020 20:07 MDT	XR Chest 1 View Frontal	Grow,MD,Robert W	24 years

Report

Pleural space:Unremarkable.

Bones and soft tissues: Normal for age.

Additional findings: None.

IMPRESSION:

No radiographic evidence for acute thoracic disease.

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